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ABSTRACT

In recent years, bulimia nervosa has plagued young women and become a major issue in mental health care. Strategies for training counseling students so as to acquaint them with clinical research on treatments for bulimia are presented in this report. It reviews empirically supported treatments (ESTs) concerning eating disorders in order to facilitate this educational process. The ESTs and evidence-based treatments described here are grounded in studies recommended by the American Psychological Association. Priority was given to carefully controlled, double-blind, randomized studies with adequate sample size and measures to assure high-treatment fidelity. Included in the treatment summaries are techniques of cognitive behavior therapy, behavioral treatment, and interpersonal psychotherapy (IPT). The steps involved in explaining the IPT concepts and contract and the way in which group therapy sessions should be structured and conducted are included in each overview. The core procedures to be utilized through Cognitive Behavior Therapy are outlined and information on the cognitive distortions and dysfunctional thinking patterns involved with eating disorders and how they affect therapy for patients with these disorders are presented. The report likewise discusses maintenance and how to cope with lapses. (MKA)

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Familiarizing Students with the Empirically Supported Treatment Approaches for Eating Disorders

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In training counseling students, it is increasingly important to acquaint them with the clinical research literature exploring the efficacy of particular treatments. This review of empirically supported treatments (ESTs) is intended to facilitate this educational process. ESTs, or evidence based treatments, are based on studies recommended by Division 12 of the American Psychological Association in their report on empirically validated psychological treatments (Chambless et al., 1996; Task Force on Promotion and Dissemination of Psychological Procedure, 1995). The original listing was recently expanded to include 57 treatments that had withstood the test of careful empirical scrutiny (Chambless & Hollon, 1998). Developing specific psychotherapeutic techniques for homogeneous populations is a current focus of psychotherapy research (Orlinsky & Howard, 1986).

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To qualify for inclusion in the EST listing, for each treatment research must have shown that it leads to a reduction or remission of the disorder or problem at a rate higher than occurs with the passage of time (efficacious) or that it outperforms an alternative active treatment (efficacious and specific). Knowledge that a treatment has been shown to be efficacious should affect decisions about how one practices psychotherapy.

Studies selected for summary were taken from the national listing of Empirically Validated Treatments developed by the American Psychological Association. The criteria for inclusion in the APA sample is described in detail elsewhere, but priority was given to carefully controlled, double-blind, randomized studies with adequate sample size and measures to assure high treatment fidelity. Most of the controlled studies of psychological treatments have been conducted on behavioral or cognitive approaches, although recently there has been increased use of clinical trials methodologies in tests of other treatment approaches, such as those based on psychodynamic theory.

Short-term Treatment of Bulimia Nervosa

In recent years, bulimia nervosa has plagued young women and become a major issue in the psychiatry and psychology arenas. Clinical evidence suggests that bulimia nervosa often runs a chronic course since most patients have exhibited many years of symptoms, and often have made previous attempts at treatment (Russell, 1979; Herzog, Keller, Lavori, & Sacks, 1991).

Both antidepressant drugs and a specific form of cognitive behavior therapy have been successful in producing substantial, short-term change (Fairburn, Agras, & Wilson, 1992).

Long-term Treatment of Bulimia Nervosa

Because of the chronic nature of bulimia nervosa, it is important to evaluate the maintenance of change after treatment since treatment effects are of limited overall benefit to the patient unless they are maintained (Fairburn, Jones, Peveler, Hope, & O'Connor, 1993). In order to create firmer conclusions about maintenance of treatment effects, this study used a closed 12-month follow-up during which time, patients were not to seek other treatment. This allowed Fairburn et al. to monitor the levels of symptoms and the patients' need for further treatment (Fairburn et al., 1993).

CBT, IPT, BT, & Long-term Treatment Effects

The dual aims of this study were to determine whether cognitive behavior therapy (CBT) for bulimia nervosa has a specific therapeutic effect and determine whether a simplified behavioral treatment (BT) of CBT is as effective as the full

treatment (Fairburn et al., 1993).

The study utilized three types of treatment: CBT, BT, and interpersonal psychotherapy (IPT) and a variety of assessment measures such as the Eating Disorder Exam and the Eating Attitudes Test to monitor changes in symptoms. Participating therapists were trained to follow manuals and utilized tape recorders to ensure consistent delivery of techniques (Fairburn et al., 1993).

The results showed that few patients undergoing BT ceased all forms of binge eating and purging which was the criteria for a "good" outcome at the end of treatment. Patients in the CBT and IPT treatments made equivalent, substantial, and lasting changes across all areas of symptoms. Although, IPT took longer to achieve success (Fairburn et al., 1993).

Cognitive Behavior Therapy (CBT)

This treatment uses both cognitive and behavioral procedures to change patients' behavior, their attitudes to shape and weight, and, when necessary, other cognitive distortions such as low self-esteem and extreme perfectionism (Fairburn, Marcus, & Wilson, in press).

Behavioral Treatment (BT)

This treatment consists solely of the behavioral procedures from CBT. The focus was on the normalization of eating habits which includes gaining control over eating, establishing a regular pattern of eating, and ceasing to diet (Fairburn et al., 1993).

Interpersonal Psychotherapy (IPT)

This treatment focuses on the patient's current interpersonal functioning. It addresses the interpersonal context in which the disorder had developed and been maintained (Fairburn, in press). There is no mention of the patient's eating problems or concerns about shape or weight other than during the initial assessment.

Conclusions About Treatment: Although CBT and IPT achieved equivalent effects, the comparison revealed the important finding that bulimia nervosa may be treated successfully without focusing directly on the patient's eating habits and attitudes to shape and weight (Fairburn et al., 1993).

Non-Purging Bulimics

Binge Eating among the obese has been recently recognized as an important clinical problem (Wilfley, et al , 1992). Among obese individuals seeking treatment, 29-55% reported binge eating (Gormally, Black, Daston, & Lardin, 1982 ; Hudson et al, 1988; Loro & Orleans, 1981; Marcus, Wing & Lamparski; 1985, Spitzer et al, 1991; Spitzer et al, 1992).

Participants in the Wilfley & Agras (1992) study ranged in age from 27 to 64 years old. The average age was 23.7 years old. The participants had been bingeing from 2 to 53 years. The pretreatment weight on average was 192 lbs, with the range from 132 to 258.5 lbs.

Some studies show that Obese binge eaters experience levels of psychopathology comparable to those of anorectic and normal-weight people with bulimia. (Hudson et al, 1988; Rather & Williamson, 1988, Shisdach, Pazdu, & Derago, 1990, Wilfrey, 1989.)

Most importantly, several studies and clinical reports show that overweight women with bulimic symptoms function less well than obese non-bingeing women (Gormally, Radin & Bloch, 1980; Keerie, Wyshogrod, Weinberger & Agras, 1984; Marcus et al 1988; Wilson, 1976).

This controlled study was conducted to verify that IPT therapy (Klerman, Weisser, Rounsaville & Chevran, 1984) was at least as effective as CBT (Fairburn, Jones, Peveler, Hope & O'Connor, 1991). The WL group or control group members were not exposed to either of the two therapies.

CBT and IPT

The two therapies differ in that CBT assumes that eliminating the dietary restriction, increasing the intake of a wider variety of foods, and decreasing the cognitive distortions are collectively sufficient for treatment effectiveness (Fairburn, 1985). These dietary restrictions and distorted attitudes are assumed to be related to the eating behavior, shape and weight of the individual.

IPT assumes that the individual must foster greater control of their current social role and adapt to interpersonal situations in order for treatment to be effective. Binge eating is brought on by the negative mood, the low self esteem , and low interpersonal functioning frequently associated with obesity in a culture that values slimness (Fairburn et al, 1991).

The following section details the Wilfley, Agras, Telch, Rossiter, Schneider, Cole, Sifford, and Raeburn (1993) Treatment Protocols:

Treatment was conducted over a sixteen week period, during which participants attended weekly 90-minute group therapy sessions. A treatment manual guided therapist interventions (Telch et al 1990).

The focus of CBT was on eliminating binge-eating, not on weight reduction. The bingeing was assumed to be the consequence of repeated restrictive dieting and the dysfunctional thoughts associated with the diet/binge cycle.

The primary goal of CBT was to establish regular healthy eating patterns. The secondary goal was weight control, but only after bingeing had been eliminated. The dietary restriction self-

imposed by the individual was reversed. Gradually, a program of consuming three or more meals per day was introduced. The range of food was widened for the individual, including those foods avoided during diets. Body image was also addressed.

Self-monitoring forms were used to elucidate dysfunctional eating patterns and to identify triggers to binge eating (eating, thinking, and mood patterns). Alternative eating patterns and coping strategies were emphasized, and unrealistic rules and fears associated with restricted eating patterns were confronted. Relapse prevention procedures consisted of problem-solving and identifying more effective methods of coping with high risk situations, urges to binge, and lapses. No attention was paid to dysfunctional relationship patterns.

IPT Treatment

IPT was originally created for depression by Klerman et al. (1984). It was then modified by Fairburn et al (1991) for patients with bulimia nervosa. The therapy used was Fairburn et al (1991) which was modified for a group format.

The IPT treatment focused on interpersonal relationships. Of the sample studied 55 % had interpersonal deficits. Social isolation, low self esteem, and the inability to form or maintain intimate relationships were common (Wilfrey et al 1992).

The binge eating is construed to be a response to interpersonal disturbances. (e.g. social isolation, fear of rejection) and subsequent negative moods. The treatment goals evolved from problem areas identified by Klerman et al (1984) ; grief, interpersonal disputes, role transitions, and interpersonal deficits. In summary, the individual is encouraged to adapt to or strengthen their social role and be adept within interpersonal situations.

The IPT therapy proceeded in three stages as specified by Klerman et al (1984):

1) Initial Sessions emphasize the affect associated with these interpersonal difficulties.
2) Address the interpersonal problems
3) Evaluate goals, explore the end of the session and outline remaining work

Note that no attention was paid to eating habits or attitudes to body shape or weight. In part, this type of therapy instructed the individuals to work on the relationship difficulties they experience in their social lives. It taught them to recognize and accept their feelings, opinions and needs and to transfer these new skills to their social lives.

Evaluation of IPT and CBT

Both subject groups were to evaluate the number of times that they binged using a 7 day calendar. The results were as follows (excluding absentee or drop out cases from each group):

The number of days bingeing reduced by the CBT group was 64 %. The IPT group reduced the number by 68 %. These results were not significantly different from each other.

In comparison, the weight loss or control group reduced bingeing by only 11 %(Wilfrey, et al , 1992). It should be noted that 45% of the sample binged 5-7 days(severe bingeing) per week. Both of the treatments were equal for the more severe Binge eaters. IPT tended to be better for the less severe binge eaters. The authors note that a larger sample of patients would be needed to verify this phenomenon.

The data presented is similar to that from a previous study (Fairburn et al.,1991). Despite the fact that IPT does not focus on the eating behavior is successful in treating non-purging bulimia. Previous research supported the use of CBT (Fairburn et al 1992). Binge eating seems to be driven by at least two factors: Highly restrictive dieting (CBT) and mood changes from interpersonal difficulties (IPT). A larger sample size would be needed to see if a correlation between reduced bingeing and increased self-esteem and mood would be realized following IPT.

The two therapies were not complementary : CBT did not address dysfunctional, interpersonal relationships. In IPT, food, eating habits, shape and weight were avoided.

Both CBT and IPT groups had an equal marked effect on decreasing the binge eating in their individual groups. Binge eating remained below baseline levels significantly at 6 months and at one year following the start of treatment.

Eating Disorders
IPT

IPT. Interpersonal Psychotherapy is a short-term, time-limited therapy that emphasizes the current interpersonal relations of the overweight binge eater. The rationale is that there is an interrelationship between negative mood, low self-esteem, traumatic life events, interpersonal functioning, and the patient's eating behavior. Central to the treatment is the notion that the eating problems constitute a maladaptive solution for the "underlying difficulties." Major therapeutic tools are well-established techniques such as clarification of emotional states, improvement of interpersonal communication, reassurance, and testing of perceptions and performance through interpersonal contact. IPT concentrates on current disputes, frustrations, anxieties, and wishes defined in the interpersonal context. The influence of early childhood experiences is recognized as significant but is not emphasized in the therapy. Rather, the work focuses on the "here and now".

IPT-Binge

The treatment is a focused interpersonal psychotherapy group that will progress through three stages (i.e., Initial, Middle, Late). It is a time-limited, short-term (20 sessions over 20 weeks) treatment focused almost exclusively on interpersonal problems and their relationship to binge eating symptoms. The

aim is to encourage mastery of current social roles and adaptation to interpersonal situations with the assumption that improvements in these areas will lead to the amelioration of binge eating symptoms.

I. a review of the patient's past interpersonal functioning (e.g., family, school, social);
II. an examination of her current interpersonal functioning (e.g., family, work, social);
III. an identification of the interpersonal precipitants of episodes of binge eating;

By the end of this initial individual intake session, the therapist and patient agree upon the interpersonal problem areas and goals. Treatment goals evolve from the four main interpersonal problem areas as specified by Klerman et al. (1984, p.88):

I. grief;
II. interpersonal disputes with spouse, lover, children, other family members, friends, co-workers;
III. role transitions - a new job, leaving one's home, going away to school, relocation in a new home or area, divorce, economic or other family changes;
IV. interpersonal deficits - loneliness and social isolation.

These identified problems and resultant goals serve as the basis for the patient's focus on interpersonal issues in group IPT. During the initial stages of IPT-G the patients learn how to use the group format to work on goals.

Identifying the patient's major problem areas to establish a treatment contract.

1. Determine which relationship or aspect of a relationship is related to the binge eating and what might change in it.

   a. Obtain a detailed review of the patient's past. The goal is to gain an understanding of the context in which the binge eating developed and is maintained. As recommended by Fairburn, the following topics are assessed one-by-one:

      1. the history of the binge eating (and changes in weight);

      2. the patient's interpersonal functioning prior to and since the development of the binge eating;

      3. the occurrence of major life events;

      4. problems with self-esteem and depression.

b. The goal is to identify connections between interpersonal functioning, self-esteem and mood, and occurrence of life events, and the onset and maintenance of the eating problem. A thorough review or these areas will reveal the relationship between these four areas.

c. Review current and past interpersonal relationships as they relate to current binge eating symptoms. Have the patient describe:

1. the nature of interaction (frequency of contact, intimacy, reciprocity) with significant persons (partner, confidants, family, friends, people at work, children);

2. her expectations of these close relationships and whether these were or are fulfilled;

3. the satisfying and unsatisfying aspects of the relationships;

4. the changes the patient wants in her relationships.

d. Identify the interpersonal and emotional precipitant of individual episodes of overeating. Binge eaters often use food to cope with negative affective states and difficult interpersonal situations. Thus, the context in which the patient binges is relevant for the identification of problem areas. Particular emphasis is placed upon any interpersonal events which might have been relevant. Aside from these inquiries during the assessment phase, it is not a goal of IPT-G to discuss eating, weight, or shape concerns. However, when this topic is initiated by group members, the therapists encourage members to discuss how this is related to their interpersonal problems.

2. Determine the interpersonal problem area related to current binge eating and set the treatment goals. The interpersonal assessment culminates in the identification of major problem areas. It should be made clear that the focus of treatment will be on the identified problem areas, as they currently affect the patient. In Wilfley et al.'s prior study there was considerable overlap in the problem areas identified by binge eaters. The most common primary problem area was interpersonal deficits which were present in 55% of the subjects. In these cases, there was a long standing history of social isolation, low self-esteem, and an inability to form or

maintain intimate relationships. Interpersonal disputes were found in 28% of the cases and was the next most common problem. All of these disputes were marital with a majority of the spouses having problems with substance abuse. In two of the cases, the wives were being pushed to enter treatment to "lose weight." The two other IPT problem areas were encountered less often. In three cases (17%) grief was the major unresolved issue. In these cases, the subjects identified bingeing as a response they used to cope with the loss of significant others. Difficulties with role transitions were only encountered as a secondary problem in two cases (one had recently retired and the other was now her mother's caretaker). Both of these individuals linked their bingeing with these significant role transitions.

Explain the IPT Concepts and Contract

1. Outline therapists' understanding of the problem and encourage the patient to discuss her understanding of the problem. The stated rationale is that binge eating occurs as a response to interpersonal disturbances (e.g., social isolation, fears of rejection) and consequent negative moods. After the assessment is conducted, the therapists can individualize the discussion of the problem to the patient's particular interpersonal history.

2. Agree on treatment goals (which problem area(s) will be the focus).

3. Describe procedures of IPT: "here and now" focus, need for patient to discuss important concerns; review of current interpersonal relations; discussion of practical aspects of treatment -- length, frequency, times, policy for missed appointments.

a. setting up the group. A circular seating arrangement is necessary as all group members must be able to see one another.

b. size of the group. Each group has nine members and two therapists.

c. duration of the meeting. The group meets for 90 minutes to allow 20 to 30 minutes for the group to warm up, and 60 minutes to work through the major themes of the session.

d. temporal boundaries. The therapists attempt to have as few interruptions in the group's time as possible. All late arrivals are discouraged and explored with other group members as to their reactions to the "late" group member/s. Ideally, all members are present at the beginning of the meeting with no interruptions until its conclusion. It is important for therapists to have

consistent time parameters, that is, begin and end promptly. A prompt beginning and ending creates a sense of consistent structure for the patients. The therapists may begin preparing their members for the close of group by making some type of closing process comment, e.g., we have about fifteen minutes left, what would you be thinking and/or feeling if we ended group at this moment? Given the work that has gone on this evening, how are you feeling towards one another? What will you be thinking on the drive home this evening?

e. contact outside of the group with other members is discouraged. During the individual sessions with the therapists, the patient is informed that members should have contact only during group time in order to have interactions contained within the group. The therapists explain that this is important as it allow group members to provide more accurate feedback and to derive more therapeutic benefit. The following explanation is given to group members: "If group members meet and have private conversations with one another outside the group, these interactions may impede the examination of the interpersonal relationships among all of the members. Extragroup socializing inhibits this examination because important material -- the relationship among the members who are interacting outside the group, feelings of exclusion in patients who are not part of this interaction -- may not be discussed which may undermine one of the primary tasks of the group."

f. pregroup preparation - pregroup preparation decreases dropouts, increases cohesiveness (i.e., attraction-to- group), and accelerates the work of therapy. Pregroup preparation is a particularly important task of the group therapists, since this group will be a short-term, focused treatment. The goals of group IPT preparation are as follows: (1) to explain principles of group therapy, (2) to describe norms for appropriate behavior in the group, (3) to establish contract about regular attendance, (4) to raise expectations about helpfulness of group, and (5) to predict early problems and minimize their impact. Underlying everything is the establishment of a working relationship.

g. procedure for group preparation - Group member preparation for group IPT will be conducted during the two hour session with both group therapists. The patient is informed about the time, location, composition, procedure, and goals of the group during this session. The therapists give a brief introduction of the interpersonal model of binge eating by discussing the importance of interpersonal relations and how disturbances in relationships underlie binge eating symptoms.

A typical group session is described in clear, concrete, and supportive terms. The therapists inform patients about how the process of understanding her relationship to other members of the group will provide her with exceedingly valuable insight into how

she creates her own outside social life. The group is described as a place to work on her identified problem areas. Subjects are told that this "interpersonal laboratory" will provide a unique opportunity to: (a) work on the relationship difficulties they experience in their social life; (b) recognize and accept their feelings, opinions, and needs; and (c) transfer newly learned interpersonal skills to their outside social life.

The therapists help the patient translate her interpersonal goals into specific ways they may materialize in the interpersonal milieu of the group. For instance, if a member struggles with interpersonal deficits it is likely that she will have a difficult time connecting with group members, and she may assume that others do not like her. Predicting these difficulties is often the first step in helping a patient work towards change.

Members are informed about what they can do to facilitate their own therapy. The therapists openly discuss with members what they can do to facilitate their own recovery. Members are encouraged to practice giving and receiving feedback as well as to make personal disclosures related to content, process, and emotion. The patient is reassured that the therapists' role is to facilitate <u>effective</u> communication, because communication which evaluates, blames, moralizes, or demands is unlikely to be useful. Therefore, although the therapists' role is highly supportive, they will also work to challenge the members to identify feelings in the "here and now" and to communicate as effectively as possible. Initially, the process of giving and receiving feedback and initiating self-disclosure will be difficult and anxiety-provoking. The members will be told that while the symptoms of binge-eating itself will not be the focus, therapists, are interested in what group members learn about how difficulties with interpersonal problems are connected with their binge eating. Thereby, IPT-G will teach the patients to begin translating what triggers their bingeing symptoms into underlying interpersonal problems (such as, lack of intimacy in relationships, inability to express anger, social isolation, hypersensitivity to rejection).

Patients are forewarned about certain stumbling blocks of the group: puzzlement, discouragement, frustration at not having the amount of personal attention they might like. The therapists predict to the patients that after a couple of sessions, they may want to drop out. Patients are instructed that this is a very common reaction and that when these feelings come up, it is important to discuss them in the group. Patients are reassured that it is highly likely that others will be having similar feelings.

Patients' conceptions and misconceptions about group therapy are elicited and discussed; and the therapists attempt to augment the patients' confidence in group therapy by emphasizing that groups do not constitute an inexpensive, second-rate therapy. The therapists also emphasize that, by providing a rich arena in which they can learn a great deal about how others perceive them

and how they relate to others, group therapy represents a unique and particularly effective therapeutic modality. In fact, what IPT-G does best is to help people understand more about their relationships with others.

One of the ways that group helps members to work on their relationships is by focusing on the relationships that develop among members. The rationale provided is that the better communication becomes with each of the members of the group, the better communication will become with people in their outside social life. For example, most binge eaters have difficulties expressing their feelings, needs, and opinions. The group is a safe place to practice expressing their needs. They may then take their newly learned communication skills to their significant relationships outside of the group.

h. <u>likely outcome</u> - patients are informed that on the basis of our previous findings that they should expect to improve their binge eating and to <u>maintain</u> their improvements. However, Fairburn suggests that two qualifications be provided: (1) patients will typically still have some problems with binge eating at the end of treatment, but often there is continued improvement over the one year follow-up period as new patterns of interpersonal behavior are being established; and (2) patients are encouraged to view binge eating as a way they have coped with stress for most of their adult life and thus, it may remain their first reaction under stress, but between such times it will often be much less of a problem. However, they may also expect to be more sensitive than the average person about eating, shape, and weight.

TASKS (Individual Intake Checklist):

Discuss chief complaint and binge eating symptoms.

Obtain history of binge eating disorder.

Establish whether or not there is a history of prior treatments for binge eating disorder or other psychiatric problems.

Conduct a thorough social history.

Assess patient's expectations about psychotherapy.

Explain IPT-G and its basic assumptions.

Translate binge eating symptoms into interpersonal context.

Reassure patient about positive prognosis.

Explain IPT-G techniques.

Contract setting for administrative details, i.e., length of

sessions, frequency, duration of treatment, appointment times, etc.

Complete an Interpersonal Inventory (detailed review of patient's important relationships).

Provide feedback to patient regarding both therapists' general understanding of the patient's interpersonal difficulties (IPT problem area<s>).

Collaborate on a contract between both therapists and patient regarding the treatment goals.

Explain tasks of therapists, patient, and group member(s) in working toward treatment goals.

EXCLUDING INCOMPATIBLE PATIENTS FROM CBT AND IPT.

Due to the random assignment of binge eaters to either group CBT or group IPT, exclusion will be conducted prior to random assignment. Participants will be women, aged between 18 and 65 years, who meet the proposed DSM-IV criteria for binge eating disorder. In addition, participants must have a body mass index (BMI) of 27 or above for inclusion into the study. A BMI of 27 or above is indicative of an overweight condition.

Participants will need to be available for both of the early evening times set aside for the groups. We will run one cohort at a time (one CBT group, one IPT group). If they can only attend one of the two specified times set for the two groups, they will not be allowed in the study since this would interfere with random assignment. They must also be available for the entire duration of the study including the one-year follow-up.

Exclusion criteria. Potential participants who meet the following criteria will be excluded: 1) associated physical or psychiatric disorder warranting hospitalization; 2) actively suicidal thoughts; 3) current physical dependence on alcohol or drugs; 4) current body mass index (BMI) below 27, thereby excluding participants who are not overweight; 5) current psychiatric treatment of any type or the current use of medication known to affect weight or eating; and 6) physical conditions (including pregnancy) or treatments known to influence weight or eating.

CBT-Binge

CBT aims to eliminate binge eating by instilling a regular, healthy eating pattern and eliminating the dietary restraint, chaotic eating and dyscontrol associated with bingeing. In addition, the cognitive, emotional, and interpersonal correlates of binge eating will be examined, and patient's will be taught

more adaptive means of managing dysfunctional though patterns, unpleasant mood states and interpersonal distress.

CBT for BED emphasizes changing dietary habits, dysfunctional thinking, and maladaptive strategies for handling negative mood states believed to contribute to binge eating. It comprises 20 weekly group therapy sessions in which the primary focus is eradication of binge eating patterns and a secondary emphasis is on how these and other changes can facilitate weight management. The core procedures to be used throughout the 20 week program, include:

1. Detailed self-monitoring of food intake, the pattern of eating, and binge eating as indicated for each session. Accurate record keeping and careful analysis of these records by the participants and therapist form the basis for therapy. The self-monitoring records are essential for identifying problems, suggesting specific behavioral changes, and monitoring the effects of the changes.

2. In addition to self-monitoring, participants will be asked to complete weekly homework assignments including a graph indicating the weekly totals of binge eating, weekly goal sheets, identifying antecedents to binge episodes, etc.

3. One major emphasis in this therapy is the establishment of a regular, healthy eating pattern, including three meals per day, scheduled snacks, a healthy eating style, healthy food choices, and lessened avoidance of specific foods. Eating more regularly, i.e., three meals a day, and a variety of foods begins to control excessive hunger, and helps to decrease the probability of binge eating. Eating small amounts of candies, sweet foods, or "forbidden foods" often reduces feeling deprived and helps overcome "all or nothing" thinking which can provoke binge eating.

4. CBT will also examine the cognitive, emotional and interpersonal contributions to the binge eating patterns. Identification of the participant's beliefs, particularly the distorted cognitions which maintain the faulty eating patterns will be explored, delineated, challenged, and reframed. A formal problem-solving process will be outlined in order to assist patients in developing alternative, adaptive coping strategies. An additional focus is on mood states which may trigger binge eating and/or be activated as a consequence of binge eating. Alternative methods (other than bingeing) for managing negative mood states should be explored. Interpersonal issues may also be identified as associated with the binge eating pattern (e.g., inability to express anger directly) and engendering patients' awareness of this association as well as suggestions for managing interpersonal dilemmas will be part of the therapeutic task. Participants will be asked to keep detailed records of their thoughts and mood states in order to identify thoughts and mood

states in order to identify dysfunctional thoughts and negative moods associated with binge eating.

5. Another focus during this initial treatment phase will be on establishing a regular exercise fitness program as a stress management strategy to combat binge eating episodes as well as being a means for promoting general physical health.

6. Finally, relapse prevention procedures should be introduced during the last few sessions.

Cognitive Distortions and Dysfunctional Thinking Patterns

One of the core features of treatment consists of identifying and challenging unproductive though patterns and distorted beliefs. One of the therapist's tasks is to help group members identify their own dysfunctional thoughts which perpetuate binge eating. Once identified the therapist should help members learn to refute and challenge maladaptive thinking and generate alternative, more adaptive thoughts.

The therapist can begin with a general discussion of the importance of thinking patterns in contributing to behavior and mood patterns, and specifically how examining and changing patients' thinking patterns will be critical to success. Presenting the material along the following lines may be useful. Explain to patients that cognitive-behavioral therapy assumes that certain attitudes or beliefs contribute to the eating problems and that changing these thought patterns will facilitate recovery from the eating problems. In this program we will begin by having you pay attention to your "internal dialogue," i.e., what goes on in your head. Do you encourage, support, and praise yourself, or punish and criticize yourself?

Emphasize that much of this self-talking goes on out of one's awareness, i.e., automatically. This is dangerous because how we think about ourselves, others, and the world significantly impacts our mood and behavior. Distorted, negative thinking often leads to depressed and anxious moods, a poor self-esteem, and compulsive behaviors. Individuals with binge eating and weight problems often talk to themselves in a very self-defeating, critical and punishing way which affects their mood state and eating behavior. Additionally, many unrealistic, irrational, defeating ideas specifically related to food, weight and dieting are maintained. Again, these ideas and ways of thinking have become automatic. The major purpose of this aspect of this program will be to increase awareness of automatic thought patterns, to identify those beliefs that are unhelpful, to challenge unrealistic thinking and to develop alternative views that are more adaptive and facilitate achievement of specific goals and enhance positive mood state. Gaining awareness and control of thinking can go a long way to improving mood and behavior.

The first step in dealing with distorted cognitions will be to identify both the beliefs associated with the binge eating behaviors and the more general cognitive environment of the patients. This involves a process of helping patients identify what they say to themselves, how they instruct themselves in general and specifically with regard to food. For example, thinking patterns prior to a binge should be identified and explored and negative self-talk in general ("I'm stupid," "I'm a failure") should be made conscious. The goal this week will be to get patients to pay attention to the content of their thoughts. Simply identifying the belief may result in the patient recognizing the distortions involved. To assist patients in developing an awareness of their cognitive environment, the therapist should review the following types of common distortions and embellish these with several examples.

Cognitive Imperatives. One type of thinking pattern that leads to trouble for patients involves cognitive imperatives. In this style of thinking many rules governing a personal behavior are framed with the words "should" and "must," and reveal the critical, judgmental and perfectionistic attitudes so common in these patients. The rules often involve unrealistic standards which will eventually be violated leading to self-condemnation. Both the cognitive imperatives and negative self-evaluation that accompanies breaking the rules should be identified, challenged and reframed. Statements such as "I should skip breakfast in order to not start the day with food on my mind" should not only be challenged consistently by the therapist, but the patient has to be persuaded to take the risk of not following through on such imperatives. Suggestions to take an experimental view of such new behavior are often successful. In the example given, the participant could be informed that clinical evidence suggests that eating a well-balanced breakfast reduces one's preoccupation with food that usually persists when one has skipped breakfast. Point out to the patient that her current belief system is not working and that it amy be worth testing out one's belief by eating breakfast a few mornings. This method of behaviorally testing out beliefs should be encouraged by the therapist.

Catastrophic and all or nothing thinking are common thinking styles that frequently get patients into trouble. Usually, in catastrophic thinking the imagined negative consequences of a particular behavior are much exaggerated. For example a belief might be "eating a piece of cake has completely blown my diet anyway so I may as well binge and start again tomorrow." All or nothing thinking might involve beliefs such as "one binge means I'm a total failure, I give up. I will never be able to lose weight." Group members should be taught to substitute more realistic and positive thinking such as "I probably shouldn't have eaten such a big piece of cake, but it's not the end of the world. I can allow myself occasional slips and not punish myself by bingeing further."

Patient's distorted thinking patterns may alternate between catastrophic predictions and rigid rules to denial,

rationalization or justification. The latter type of thinking involves "fooling" oneself. For example, convincing oneself that since breakfast was skipped and lunch consisted of only an apple, "snacking" on a basket of chips at a Mexican restaurant before eating a large burrito really won't matter. Here instead of the consequences being greatly exaggerated, they are minimized or denied. Both types of thinking can lead to problems and require consistent challenge and reframing.

Explain that over the course of the treatment program group members will be taught to identify dysfunctional thoughts that negatively affect mood states and behavioral performance and to substitute more adaptive thinking that facilitates carrying through one's goals. The first step toward achieving this aim is to teach group members to identify their individual dysfunctional thinking patterns. The group leader should distribute the dysfunctional thoughts record and self-talk handout at this time, and instruct the group members as to how to complete these forms during the upcoming week. Emphasize that at this point the purpose is to have patients become aware of their dysfunctional thoughts, which include unrealistic shoulds, rules, negative self-talk, etc. We will discuss changing thought patterns in a later session. Patients should be instructed to use the thought record when they have binge urges or episodes and use the self-talk form to identify one or two general negative or dysfunctional thoughts this week. They need not complete the columns on the self-talk form which refer to altering or changing thinking patterns. This will be next week's topic.

Suggest to participants that they set goals in the above two areas.

Examination of Dysfunction Thoughts Records

The group focus should next shift to a review of last week's discussion on dysfunctional thinking and cognitive distortions. Briefly highlight the main points of that discussion, especially the notion that automatic, negative thinking patterns and rigid, unrealistic rules and assumptions influence mood and behavior patterns. The purpose here is to increase awareness of thinking patterns contributing to negative mood and binge eating. Once identified, these unhelpful thought patterns can be challenged and replaced with more adaptive thoughts that facilitate binge free patterns.

The participants' thoughts records should be examined at this time. The therapist should inquire as to any difficulties participants are experiencing in identifying the content of their automatic thinking. Remind patients that this task can be difficult at first given the automatic nature of our thinking but with practice the task should be easier.

Ask the group members to volunteer examples from their records. Have the group as a whole consider the thoughts volunteered and ask themselves questions such as:

"Is this all or nothing thinking?"

"Am I catastrophizing?"
"Am I denying or justifying bingeing?"
"What evidence is there about the validity of this thought?"
"Am I being self-critical or too hard on myself?"

The therapist should help group members learn to identify and become aware of maladaptive thinking patterns.

Next begin helping group members to challenge any distorted beliefs and generate more adaptive thoughts. That is, teach the participants to refute or challenge their distorted cognitions and substitute more realistic and constructive thoughts. This should be accomplished by role-playing with the group members. First, have a few participants read one or two of the thoughts that preceded a bingeing episode. The therapist should challenge these distorted cognitions and suggest several alternative, adaptive coping self-statements to substitute for the dysfunctional ones. Then have group members do the challenging and devising of coping statements in response to the dysfunctional thoughts of the participants. After a few examples via role-playing, the group members should take out their self-talk form completed during the week and fill in the columns for challenging negative self-talk and replacing more adaptive thinking. The therapist should assist any patients having difficulty with this task. Group members should continue using the dysfunctional thoughts records and the self-talk form during the upcoming week and in addition to identifying the dysfunctional thinking, should also record a few alternative, adaptive thoughts to replace the dysfunctional ones. The thoughts preceding, during, and following eating and bingeing should be the focus of the monitoring.

Maintenance and Coping with Lapses

Next the therapist should introduce the topic of maintenance and relapse prevention. Explain that what we mean by this is helping patients to continue with progress made and maintain the changes in thinking, eating, mood, interpersonal and coping patterns. Occasional setbacks or lapses into old patterns will probably occur and do not invalidate progress made. What's important is that the lapse be temporary and not escalate in to a long-term return to old maladaptive patterns. A setback should be taken as an opportunity to learn and increase awareness. In order to prevent a setback from becoming a full-blown relapse, it will be important to identify immediately any early warning signals. Therefore, the first goal is to prevent the occurrence of initial lapses into previous patterns by continuing to follow through on goals set and changes made. Second, it will be very important to recognize early warning signs of slipping back into old patterns such as eating in the car, inappropriate meal selections, eating out of boredom, etc. Third, these sorts of lapses or actually having a binge episode should be met immediately with a preplanned coping strategy for getting back on track.

Emphasize that it is equally important to have a planned and rehearsed coping plan. The fire drill analogy conveys this point nicely. We do not expect to have to use fire evacuation procedures, but we nevertheless have a well rehearsed plan to immediately institute should a fire, or even the threat of a fire, occur. Lapses are not due to inner weakness but to inadequate coping with high risk situations. Learning to cope better with such situations should help promote continued improvement.

Remind patients that lapses will probably involve a sequence or interrelationship of events including interpersonal events, mood, thinking and eating patterns. It will be important for patients to isolate each link in this sequence of events and develop separate strategies for coping with each. Explore and review coping strategies that have helped in the past, and encourage the patients to discuss strategies they have developed.

The following exercise can be introduced as a method for helping to develop coping strategies so that group members have a preplanned and rehearsed strategy available. Instruct each member to envision one or two personal high risk situations and the desired outcome in these situations; i.e., refraining from binge eating. For example, the high risk situation might be having an argument with a co-worker before leaving work and the desired outcome is eating a regular dinner meal and not bingeing after arriving home from work. Each member is to outline the specific steps engaged in that enabled the desired outcome to not binge eat. In the example given, the person might have called a friend to discuss the work incident and then eaten dinner at a restaurant to reduce the possibility of being alone at home and bingeing. Each group member should have the opportunity to practice this exercise in the session, perhaps dividing the group into dyads to insure there is sufficient time to do this. Encourage patients to visualize and express in detail what they did, thought, and felt that enabled them to confront a high risk situation and not respond by binge eating. Instruct patients to monitor warning signals for lapses and coping using the prepared form.

Triggers to Bingeing and Coping

If there is time remaining, the therapist can begin a discussion of the relationship between mood, thinking and interpersonal patterns and binge eating. Remind patients that the essential first step in overcoming problems in these areas is developing an awareness of the link between binge eating and mood, dysfunctional thinking and interpersonal style. Encourage patients to discuss problems identified in these areas and involve the group in helping to problem-solve, and challenge distorted thinking and assumptions. Ask whether patients were able to successfully avoid bingeing in high risk situations by employing coping strategies discussed in previous sessions. Again, the purpose here should be to use 1 or 2 patients'

disclosures as demonstrations of identifying antecedents to binge episodes and developing alternative coping strategies.

WEIGHT LOSS

While not an EST specifically identified by APA, nonetheless this report describes a technique that has been empirically validated.

Binge Eating Disorder

It has only recently been recognized that obese individuals that indulge in problematic binge eating have an important clinical problem. Some reports estimate that out of all overweight individuals seeking treatment, anywhere from 23% to 55% report binge eating. Studies also show that binge eating increases concurrently with adiposity, which puts these individuals at high risk for medical complications associated with obesity. Those suffering from BED are indulge in episodic binge eating without purging and are often overweight. In many cases, as the person becomes increasingly overweight the episodes of binge eating increase also. Many individuals with BED also suffer from comorbid psychopathology. The combination of the two poses a serious threat to these individuals' mental and physical well-being.

A study done by Agras et al., (1995) investigated the effectiveness of group interpersonal therapy in treating overweight individuals suffering from binge eating disorder that did not respond well to 12 weeks of group cognitive-behavioral therapy. Out of two hundred sixty-two respondents, only 50 were entered into the study. Respondents were excluded because they did not meet criteria for overweight, for binge eating frequency, because they were currently purging, or for a variety of other reasons. The 50 eligible participants were randomly assigned to either 24 weeks of treatment or to a waiting-list control group. Thirty-nine participants were assigned to the treatment group and the remaining were assigned to the control group. The individuals that met the three criteria which constituted success in the initial CBT phase, proceeded with weight loss treatment, while the remainder proceeded with IPT. Measurements of binge eating and weight were taken before treatment, and at 12 and 24 weeks.

The investigators first wanted to ascertain whether or not the treatment package as a whole was more effective than the control group. Over the 24 week period, the treatment group decreased the number of days on which binges occurred by 77% whereas the control group only decreased the number of days by 22%. The individuals in the treatment group decreased their weight by 0.6 kg, while weight in the control group increased by 4.1 kg. Secondly, those who went through 12 weeks of IPT because they did not improve from the first 12 weeks of CBT, experienced an increase in weight and binge eating. These increases were not significant using repeated measure MANOVA for a within group

comparison. The individuals that did responded to CBT, and went on to weight loss treatment lost 4.1 kg over the 12 week period. Binge eating also remained at a low level within this group.

The investigators were surprised by the relative ineffectiveness of IPT to add to the effects of CBT. They felt it was possible that the IPT offered was deficient in some respect. The investigators felt that these findings emphasized the importance of discovering methods for improving those who do not respond to initial treatment.

Wilfley et al. did a controlled comparison between group cognitive-behavioral therapy and group interpersonal psychotherapy for nonpurging bulimic individuals to evaluate there effectiveness for binge eating. The subjects in this experiment were recruited using a newspaper add which offered free treatment to individual suffering from compulsive binge eating. Out of the initial respondents, there were 56 female subjects which, upon screening, met the criteria and included into the study. Participants were randomly assigned to one of the following groups: group cognitive-behavioral therapy (CBT), group interpersonal psychotherapy (IPT), and a waiting-list group (WL). There were 18 clients in the CBT and IPT group, and 20 assigned to the WL group. All subjects were assessed at baseline and given a 16-week follow-up. In addition, members of both the IPT and CBT were given 6- and 12-month follow-up assessments. The assessments consisted of a frequency of binge eating measurement, and the filling out of several questionnaires.

The 16 week assessment revealed that the IPT group reduced bingeing by 71% with 44% of them maintaining abstinence. A 48% reduction was seen in the CBT group, with 28% of them remaining abstinent. The WL group only saw a 10% reduction in bingeing, with 0% of them practicing abstinence. While both the IPT and CBT group were significantly superior to the WL group, they were not significantly different from one another. The 12-month assessment revealed that compared to baseline, there was a 55% reduction in days binge among the CBT group and a 50% reduction among the IPT group. This was however, a significant increase from the 16-week assessment. Again, there was no difference between the IPT and CBT groups.

The researchers felt this study was important in that it demonstrated that treatment for bulimia does not have to focus on eating behavior to be successful. It also supports the efficacy of both IPT and CBT therapy. However, neither was effective in helping individuals lose weight. Further studies could be done to see if a combination of treatments or longer treatments might facilitate weight loss.

Bolocofsky, Spinler, and Coulthard-Morris (1985) compared behavioral treatment for weight change with and without hypnosis. The behavioral method consisted of collecting weight history, self-monitoring instruction, keeping a weight diary, progressive relaxation, and rule adherence. The hypnosis method entailed

self-hypnosis (LeCron, 1964) and therapist-induced hypnosis. The results indicated that, at termination of treatment, both groups significantly improved. However, at 8 months and again at 2 years, clients in the hypnosis group showed additional significant weight loss.

Wheeler and Hess (1976) compared behavioral treatment for juvenile obesity with non-treatment controls in a group of mother-child pairs. The behavioral method consisted of recording all eating behaviors, specific and limited manipulation of disruptive elements of eating, examining weight change after manipulations and provide reinforcement for positive changes, gradual movement to a stable and satisfactory system, and understanding that mother and child are responsible for analysis and control. The results indicated that the treatment group showed far more improvement in reaching controlled positive eating practices than did the untreated group.

Epstein, Valoski, Wing, and McCurley (1994) examined four treatment studies for childhood obesity which collectively included parent targeting, child targeting, diet, information, lifestyle, family histories, aerobics, and calisthenics (Epstein, Valoski, et al., 1990; Epstein, Wing, Koeske, Andrasik, & Ossip, 1981; Epstein, Wing, Koeske, & Valoski, 1986, 1987; Epstein, Wing, et al., 1984; Epstein, Wing, Valoski, & Gooding, 1987; Epstein, Koeske, & Wing, 1984). "Significant effects were observed when parents and children were targeted and reinforced for weight loss in comparison with nontargeted controls and for children given lifestyle or aerobic exercise in comparison with a calisthenics control. Thirty-four percent of the variance in change in percentage overweight was predicted from sex, baseline percentage overweight, self-monitoring weight, meals eaten at home, and family and friends' support for eating and exercise.

Agras, Schneider, Arnow, Raeburn, and Telch (1989) compared a wait-list control with self-monitoring of caloric intake and purging behaviors, cognitive-behavioral treatment, and cognitive-behavioral treatment combined with response prevention of vomiting. The self-monitoring method entailed recording eating behaviors and then examining these records in detail with the therapist. The C-B treatment consisted of self-monitoring, behavior-change prescriptions (e.g., eating three adequate meals a day), critical examination of rules and fears associated with food and binge eating, challenging distorted thinking patterns, and relapse prevention. The response-prevention condition entailed the cognitive-behavioral treatment as well as consuming food enough to elicit an urge to vomit. This urge was allowed to dissipate over the remainder of the session, during which distortions of bodily feeling and cognition were explored with the patient. The results showed that all treatment groups experienced significant improvement although the wait-list group did not. The cognitive-behavioral condition, however, showed the

most improvement; thus, the response prevention method did not enhance the C-B method.

A study by Telch, Agras, Rossiter, Wilfrey, and Kenardy (1990) evaluated the initial effects of cognitive-behavioral therapy (CBT) in nonpurging bulimic subjects. This efficacy study compared the experimental group, those receiving CBT, with a wait-list control. At post-treatment, 79% of the CBT group reported abstinence from binge eating and 94% indicated a decrease in binge eating behavior. While in the control group, there was only a 9% decrease in binge eating behavior and a 0% abstinence rate. A ten-week follow-up assessment indicated a significant return of binge eating behavior but these levels showed improvement in comparison to baseline levels.

Subjects were randomly assigned tot the wait-list and the CBT groups. Subjects in the wait-list group were assessed twice, once at baseline and again ten weeks later. After the waiting period, the subjects received the CBT and were assessed and the end off the treatment. Subjects initially receiving CBT were placed in one of two identical treatment groups. They attended a weekly group session 90 minutes in duration. The therapist followed a manual outlining the content of each session. The manual was modeled after a previous manual developed by Agras et al. (1989) for bulimia nervosa, modified for use with nonpurging obese binge eaters. CBT subjects were told that treatment eradicated binge eating patterns and not designed to help with weight loss. Also, they were informed that binge eating patterns had developed as a response to repeated restrictive dieting and binge eating behavior must be eradicated to restore healthy eating habits. Participants were taught to self-monitor their eating patterns, binge episodes, thoughts, moods, and well as the circumstances surrounding their eating. They did not monitor their weight.

The results suggest a positive effect of CBT for patients with bulimia nervosa who are overweight and do not purge. The study also shows a decline in the level of improvement from the time of therapy completion until the 10-week follow-up assessment. The researchers attributed this significant decline to the brevity of the treatment, suggesting that additional treatment, including some form of relapse prevention, may enhance maintenance. A second suggestion from the researchers was that the subjects did not lose weight during the study causing them to revert to self-imposed restrictive dieting following treatment. Telch et al. suggest the subsequent use of behavioral therapy for weight loss follow CBT for binge eating in hope to facilitate a better recovery from binge eating and being overweight.

Thackwray, Smith, Bodfish, and Meyers' purpose of this study was to determine the relative efficacy of cognitive-behavioral (CB) and behavioral treatment (BT) approaches for bulimia nervosa. Subjects were randomly assigned to either the CB, BT, and an attention placebo group. At post-treatment, 92% of the CB

group, 100% of the BT group and 69% of the nonspecific monitoring placebo group were abstinent from bingeing/purging behavior.

The nonspecific self-monitoring placebo control group received attention and assessment of the reactive effects of self-monitoring instilling positive expectancies. Subjects in this group numerically indicated daily binge-purge episodes, but did not address changes in eating habits.

Those in the BT group were presented with a behavior eating habit control program (Brownell, 1985; Mahoney & Mahoney, 1976; Stuart & Davis, 1972) that was modified to control bingeing and purging. In the first few sessions, the subjects and therapist outlined behavior changes that would maintain their present weight while shaping sensible food intake plan, including binge foods. In the later sessions, subjects, with the aid of a therapist, identified environmental factors believed to be antecedents of bingeing and purging, and created strategies for dealing with environmental events. The CBT group received therapy resembling an abbreviated version of Fairburn's (1985) CBT program. The earlier therapy sessions were similar to those of the BT group but the latter sessions followed a cognitive-behavioral model with cognitive activity viewed as the mediator between environment, behavior, and consequences.

All of these groups displayed significant reduction in the number of binge-purge episodes. Those subjects in the CBT and BT groups had a significantly higher proportion of abstinence behavior when compared to the control group. One finding, according to Thackwray et al. (1993) was the follow-up rate of abstinence for CBT given such a surprisingly short treatment period. The researchers suggest the rate is due to this study's emphasis on homework and outside-of-treatment practice which led to more confidence in CBT skills. Clearly, further investigation in the area of CBT and bulimia nervosa is necessary in order to provide a fuller understanding of these issues.

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